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No. 80-1429

IN THE
Supreme Court of the United States
OCTOBER TERM, 1980

DUANE YOUNGBERG, *et al.*,
Petitioners
v.
NICHOLAS ROMEO, an incompetent, by his Mother and Next Friend, PAULA ROMEO,
Respondent

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

MOTION OF THE AMERICAN PSYCHIATRIC ASSOCIATION FOR LEAVE TO FILE A MEMORANDUM AS AMICUS CURIAE AND MEMORANDUM OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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MOTION OF THE AMERICAN PSYCHIATRIC ASSOCIATION FOR LEAVE TO FILE A MEMORANDUM AS AMICUS CURIAE

Pursuant to Rule 36.1 of the Rules of this Court, the American Psychiatric Association ("APA") submits this motion to file a memorandum as *amicus curiae*. Petitioners have consented to the filing of this brief (Appendix A); respondent has refused consent.

As noted in "Interest of Amicus Curiae," the APA has participated in numerous cases involving mental health issues. See *Pennhurst State School and Hospital* v. *Halderman*, Nos. 79-1404, 79-1408, 79-1414, 79-1415, and 79-1489, decided April 20, 1981; *Parham* v. *J.R.*, 442

U.S. 584 (1979); *Addington* v. *Texas*, 441 U.S. 418 (1979); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). These cases have presented troublesome questions regarding the extent of state obligations towards the mentally-ill (*O'Connor; Addington; Parham*) and the mentally-retarded (*Pennhurst*). In its submissions, the APA has sought to assist the Court in developing legal doctrines that promote, rather than hinder, efforts to improve the quality of care and treatment for the mentally-ill and mentally-retarded.

The decision of the Third Circuit in the present case authorizes a substantial intrusion by the federal courts into medical decisions. Certain forms of treatment, for example, may be permitted only if shown to be the least restrictive form of treatment available, even though they may be the most desirable methods of treatment from a medical standpoint. Other treatment decisions, mistakenly supposed by the court of appeals to involve purely legal questions, must be justified by showings of compelling or substantial necessity. In addition, the decision below may well drive needed doctors and employees from state facilities because they are subject to damages for institutional inadequacies that they cannot correct. The APA believes that it can supply particular insight, not fully provided by the parties, into the practical and medical realities inherent in the care and treatment of the mentally-retarded.

The development of constitutional standards for care of the mentally-retarded involves a complex balancing process in which medical issues necessarily play a prominent role. Psychiatrists have major responsibility in the development of programs for the mentally-retarded, and many psychiatrists are employed at state and local facilities. The APA believes, therefore, that this Court will benefit from its views as well as the views of advocates for the mentally-retarded and of state officials.

APPENDIX

[EMBLEM]

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL
March 11, 1981

LeRoy S. Zimmerman
Attorney General

Reply To:
1641 Strawberry Square
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Joel Klein, Esquire
2250 M Street
Suite 425
Washington, D.C. 20037

Re: *Youngberg* v. *Romeo*,
No. 80-1429 (U.S. S.Ct.)

Dear Joel:

It is my understanding that you are preparing, on behalf of the American Psychiatric Association, a brief in support of the grant of a writ of certiorari in the above-captioned case. Pursuant to Rule 36 of the Rules of the Supreme Court of the United States, please be advised that petitioners consent to the filing of such a brief.

For your information, I am also enclosing a copy of our petition (without appendix) and a draft of the brief of other states in support of the grant of certiorari in this case.

Sincerely,

/s/ David H. Allshouse
DAVID H. ALLSHOUSE
Deputy Attorney General

DHA/esm
Enclosures

It is therefore respectfully submitted that this motion to file a memorandum as *amicus curiae* should be granted.

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MEMORANDUM OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Psychiatric Association (APA) was founded in 1844 and is the Nation's largest organization of qualified doctors of medicine specializing in psychiatry. Twenty-six thousand of the Nation's approximately 33,000 psychiatrists are members. Psychiatrists bear a major responsibility for evaluating, developing programs for, and caring for the mentally-ill and the mentally-retarded.

The APA has previously participated as *amicus curiae* in numerous cases involving mental health issues. See

Pennhurst State School and Hospital v. *Halderman*, Nos. 79-1404, 79-1408, 79-1414, 79-1415, and 79-1489, decided April 20, 1981; *Parham* v. *J.R.*, 442 U.S. 584 (1979); *Addington* v. *Texas*, 441 U.S. 418 (1979); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). The present case involves significant issues regarding care of, and responsibility for, the mentally-retarded, including the establishment of constitutional standards for treatment and the likely imposition of personal liability on individuals unable to correct institutional inadequacies. The APA believes that its clinical experience and insight concerning the mentally-retarded can assist the Court in addressing the important issues in this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

The decision below announces novel and complex constitutional doctrines governing care and treatment of the mentally-retarded. Under the rubric of substantive due process, the Third Circuit has devised varying standards that state employees must satisfy in making judgments about use of physical restraints, in protecting against injuries by and to residents, and in developing individual treatment programs. At the same time, the court has made clear that state officials will be liable for failure to meet those standards even though the default resulted from institutional inadequacies beyond their control. Although the court of appeals appears to have acted from a genuine concern for the mentally-retarded, we believe that its decision may ultimately do more harm than good. At the very least, this Court should grant review to resolve these troublesome issues.[1]

[1] The issues in this case are left open by *Pennhurst State School and Hospital* v. *Halderman*, —— U.S.L.W. —— (April 20, 1981). Although the Third Circuit made frequent references in the opinion below to its earlier opinion in *Pennhurst*, see, e.g., Pet. App. at 3a n.1, 9a n.10, 10a-11a n.12, 37a n.55, it appears that the constitutional holdings below stand independent of the statutory

The potential mischief of the decision below stems from two different aspects. First, it demonstrates that the Due Process Clause is an unreliable text in which to divine constitutional guidelines for treatment of the mentally-retarded. Left largely to its own devices, the Third Circuit not only has placed the federal courts squarely in the middle of individualized treatment decisions, it has needlessly inhibited discretion by insisting that certain decisions be made in certain ways, despite the existence of other acceptable treatments. Pages 3-12 *infra*.[2] Second, the decision makes individuals liable for institutional failings beyond their control. Whatever past abuses may have been, it is unfair to impose liability on persons without fault simply because they, unlike the states for which they work, have no absolute immunity from suit. Pages 12-15 *infra*.

ARGUMENT

I. THIS COURT SHOULD GRANT CERTIORARI TO REVIEW THE SUBSTANTIVE DUE PROCESS STANDARDS IMPOSED ON STATE INSTITUTIONS.

The Due Process Clause of the Fourteenth Amendment provides that no state shall "deprive any person of life, liberty, or property without due process of law." In reliance upon that general language, the Third Circuit has seen fit to establish substantive criteria to govern the operation of state facilities for the mentally-retarded, directing state officials to apply multifarious standards according to whether restraint, protection, or treatment

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holdings in *Pennhurst*. A remand for reconsideration in light of *Pennhurst*, therefore, would not appear to be appropriate.

[2] The limitations on professional discretion imposed in this case are closely related to issues involving the right to refuse treatment, which are presently before this Court. *Okin* v. *Rogers*, No. 80-1417, certiorari granted, April 20, 1981.

is involved. The result is that medical judgments must now be tempered, and in some instances displaced, by judicial opinions regarding desirable care. In our view, that degree of judicial oversight is neither required by the Constitution nor desirable as a method of upgrading state programs.

1. This Court has previously recognized that courts have no special expertise in medical matters. See *Parham* v. *J.R.*, 442 U.S. 584, 606-609 (1979). Notwithstanding that fact, it is understandable that courts, confronted by signs of social default in the case of mentally-retarded persons, will reach out to improve conditions by whatever means are at hand. Cf. *Bell* v. *Wolfish*, 441 U.S. 520 (1979). The fact remains, however, that the wrong effort is often worse than no effort at all. It does not help the mentally-retarded when principles of law and medicine are out of joint. See generally *Addington* v. *Texas*, 441 U.S. 418 (1979).

The Due Process Clause is, at best, an awkward starting point for the revision of state medical programs. Because the Clause was aimed at very different problems, neither its language nor its history sheds any real light on state obligations in this complex, troublesome area. Nor is it possible to extrapolate these obligations from due process decisions in other areas, where the emphasis has been principally on assuring procedural safeguards rather than on limiting the substantive judgments to be made by the decision-maker. See *Addington* v. *Texas*, *supra*; *Parham* v. *J.R.*, *supra*. As a consequence, the federal courts are asked to make sensitive judgments virtually without guidance and, correspondingly, virtually without restraint.

This freedom leads to two unfortunate tendencies. First, the courts naturally turn for guidance towards doctrines developed in other contexts, like tort law, a

process that blurs meaningful distinctions between constitutional wrongs and other grievances.[3] Indeed, the court below has made it easier in some instances to plead a constitutional claim than a malpractice claim.[4] Second, the courts tend to use the few Due Process principles at hand, like the idea of a least restrictive alternative, even though they have limited utility in the particular situation. There is no reason to conclude, for example, that the least restrictive treatment is better at all times for every mentally-retarded person, even assuming that it were possible to determine what that treatment might be.

Although the Third Circuit in this case makes a conspicuous effort to separate legal and medical doctrines, the attempt is ultimately unsuccessful. For example, it is fanciful to distinguish the shackling and protection issues, described by the court as "undiluted legal concerns," from the treatment issues, said to "entail[] mixed questions of law and medical judgment." Pet. App. 14a. Decisions about restraints and exposure to other residents, matters directly involving the risks and benefits of freedom and social interaction, are frequently made in the context of an overall treatment program. See Rosen *et al.*, *The Role of Physical Restraint in the Treatment of Psychiatric Illness*, 39 J. Clin. Psychiat. 228 (1978); Bursten, *Using Mechanical Restraints on*

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[3] Reviewing a civil rights claim protesting inadequate medical care to a state prisoner, this Court has noted: "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." *Estelle* v. *Gamble*, 429 U.S. 97, 106 (1976). Similarly, the mere fact of residence in a state facility should not convert all state torts into due process claims.

[4] In general, a physician is liable for malpractice only if the care provided falls below the level of acceptable treatment. Under the decision below, however, a physician may be liable for a constitutional tort even though his treatment is professionally acceptable if it is not also the least restrictive treatment available.

Acutely Disturbed Psychiatric Patients, 26 Hosp. & Comm. Psychiat. 757 (1975); Soloff, *Physical Restraint and the Nonpsychotic Patient: Clinical and Legal Perspectives*, 40 J. Clin. Psychiat. 302 (1979). Indeed, the court itself recognized (without any apparent effect) that restraints may be part of an acceptable form of therapy, Pet. App. 20a n. 29, and that it may be "therapeutically more desirable to have an admittedly aggressive patient mingling with others instead of confined to an isolated cell." Pet. App. 26a n. 38. See discussion of this issue in Gutheil, *Restraint Versus Treatment: Seclusion as Discussed in the Boston State Hospital Case*, 137 Am. J. Psychiat. 718 (1980); Gair, *Limit-Setting and Seclusion in the Psychiatric Hospital*, Psychiat. Opinion 15 (Feb. 1980); Gutheil, *Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient*, 135 J. Am. Psychiat. 325 (1978); Soloff, *Behavioral Precipitants of Restraint in the Modern Milieu*, 19 Comprehen. Psychiat. 179 (1978); Plutchik *et al.*, *Toward a Rationale for the Seclusion Process*, 166 J. Nervous & Mental Disease 571 (1978). Despite these observations, the court confidently preempts state decision-making in the belief that restraint and protection involve "purely legal issue[s]." Pet. App. 27a.

This beguiling illusion leads to far too rigid a constitutional doctrine. Thus, for example, with regard to shackling of any sort (and apparently for any duration), the court requires both that it be justified by compelling necessity and that it be the least restrictive means of handling the resident. Pet. App. 18a. The court does not explain, and perhaps could not explain, how the term "least restrictive" is to be applied in medical terms where possible restraints may include isolation or a variety of medications, as well as the restraints used here. See Hoffman *et al.*, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 S. Diego L. Rev. 1100 (1977); Perr, *The Most Beneficial*

Alternative: A Counterpoint to the Least Restrictive Alternative, VI Bull. of Am. Ac. of Psychiat. and the Law, No. 4, iv (1978); Bachrach, *Is The Least Restrictive Alternative Always the Best? Sociological and Semantic Implications*, 31 Hosp. & Comm. Psychiat. 97 (1980); Appelbaum, *Least Restrictive Environment: Some Comments, Amplification*, 31 Hosp. & Comm. Psychiat. 420 (1980).[5] Turning to protection, the court changes its tack to require substantial (rather than compelling) reasons to justify the level of risk, suggesting that this standard will "enable[] a court and jury to distinguish between isolated incidents and inadvertent accidents, on the one hand, and persistent disregard of patients' needs, on the other." Pet. App. 25a. Even leaving aside the fact that some isolated incidents are far more injurious than repetitive minor incidents, it is not all clear why substantial necessity rather than acceptable medical judgment is the constitutional minimum.[6]

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[5] Although the notion of a least restrictive treatment is superficially enticing, the concept in practice may be almost unworkable. To begin with, it is extremely difficult to tell whether confinement to a room, for example, is more or less restrictive than administration of a drug that permits the resident to remain with other residents in a group situation. The difficulty is made worse by the fact that some treatments may be more intensive but of shorter duration, forcing doctors to balance the "restrictiveness" of a short-term treatment imposing substantial restraints against a longer course of treatment with less restraints. Furthermore, the lessening of restrictions for one resident may lead to an increase in restrictions on other residents. To determine a single supposed least restrictive treatment for each resident from this complex of variables is beyond the power of most doctors and, we suspect, most judges as well.

[6] The mistaken belief that shackling and protection raise purely legal issues also encourages the court to adopt shifting tiers of review depending on the type of decision involved. These differing standards only make the task of reaching professional judgments

The court is on even more slippery ground in defining the constitutional standards for treatment. While the court allows some decisions to be justified as "acceptable . . . in light of present medical or other scientific knowledge," Pet. App. 38a, a standard that appears largely indistinguishable from state tort standards, it directs that any decision involving "significant deprivations of liberty" be tolerated only if it "provided for the least intrusive treatment available under the circumstances." Pet. App. 47a. Although this Court has admonished that "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments," *Parham* v. *J.R.*, *supra*, 442 U.S. at 607, the court of appeals is thus forcing state physicians to choose a particular mode of treatment (determined after the fact according to an ephemeral "least intrusive" standard) even though another form of treatment would be acceptable or even preferable from a medical standpoint. Indeed, under this doctrine, doctors seemingly will be liable for constitutional torts where they would not be liable for malpractice under state law. See note 4 *supra*.

This curious result is apparently quite intentional. Without identifying any medical basis for its view, the Third Circuit has adopted a principle that treatment in state facilities must be risk-averse. Noting that individuals are usually allowed to err on the side of risk, the court nonetheless declares that "[w]hen the state is the decision-maker, the converse would seem appropriate: such actions should err on the side of safety." Pet. App. 32a n. 45. Although safety considerations are part of

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more uncertain. It is hard enough to know what conduct is required under any particular standard; it is doubly hard to know what standard is to be applied in any particular case.

any medical judgment,[7] the decision below thus forces physicians to elect only the safest treatment for state residents even though more effective treatments would be followed for other retarded persons.[8] The record of a single action for damages is not an adequate basis for so fundamental a reordering of state treatment programs.

It is important to keep in mind that the issue here is not procedural but substantive. Compare *Addington* v. *Texas*, *supra*; *Vitek* v. *Jones*, 100 S.Ct. 1254 (1980); *Parham* v. *J.R.*, *supra*. Whereas procedural due process assures that the decision-maker has an adequate and timely base of information on which to decide, and generally requires that the resulting decision not be arbitrary or capricious, the substantive due process requirements laid down by the Third Circuit compel a particular decision in most cases, even though a different decision would be neither arbitrary nor capricious.

The entry of federal courts into this field has important implications. Although this Court has made clear that states cannot commit individuals, or move them from prisons to hospitals, without extending some form of procedural due process, *Addington* v. *Texas*, *supra*; *Vitek* v. *Jones*, *supra*, it has not yet tackled the states on the

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[7] "In determining the most beneficial alternative for a given patient, consideration of the least restrictive setting is certainly appropriate, but it is one of many factors which should include likelihood of success in altering the course of mental illness and the likelihood of preventing the chronicity which so many recent policies actually seem to encourage." Perr, *The Most Beneficial Alternative: A Counterpoint to the Least Restrictive Alternative*, IV Bull of Am. Ac. of Psychiat & the Law No. 4, iv, vii (1978).

[8] Indeed, the use of the most cautious treatment may extend the length of a resident's stay in a state facility, thus increasing the loss of liberty involved in the initial commitment. While such treatment may well be appropriate in individual cases, the Third Circuit has written that requirement into the Constitution with little evident awareness of the competing interests involved.

particular substantive standards to be applied in each case. Yet, if a state must choose the "least restrictive" method of treatment for a patient admitted to a mental facility, on the ground that other methods needlessly encroach upon an incremental liberty interest, it may follow that a state cannot proceed with involuntary commitments at all except upon a showing that confinement itself is the least restrictive method of dealing with the mental condition in question. A state obviously would be hard pressed to provide care and treatment for all mentally-retarded persons without confinement of some sort, but the Third Circuit has also said quite plainly that "except in emergency situations, inadequate resources or administrative rationales offer an insufficient basis for intrusions [like shackling] on a fundamental liberty interest." Pet. App. 18a. Carried to its logical conclusion, therefore, this approach could prevent confinement of mentally-ill or mentally-retarded persons at all, unless the state could show that no other less restrictive care and treatment was available regardless of cost or feasibility. These requirements would be difficult, if not impossible, for states to meet.

We also question the theory that the provision of acceptable medical treatment within an institution may nonetheless violate the liberty interests of its residents. It is not unreasonable to suppose that a broad range of permissible treatment and restriction, left largely to the professional discretion of the staff, is inherent in the original commitment to a state facility. Indeed, the due process safeguards preceding admission are intended to insure that these significant limitations are imposed only in proper cases. See *Addington* v. *Texas*, *supra*. Once admission has been legally authorized, however, it also stands to reason that conduct within that permissible, anticipated range does not amount to a constitutional violation. Under this view, only conduct falling well below the acceptable standards, either because of the

unusual severity of a particular isolated occurrence or because of a more systematic, repetitive abuse of basic standards, would support a civil rights action. See Pet. App. at 48a *et seq.* (concurring opinion) ("substantial departure from accepted professional judgment, practice, or standard"). Traditional complaints of assault or malpractice would remain the province of state law.

Such analysis would seem to have practical, as well as conceptual, advantages. First, it avoids the necessity for a graduated system of liberties, whereby commitment invades one set and various acts of treatment or temporary confinement invade another. Second, it provides a reasonable dividing line between ordinary torts and constitutional violations, putting the second class on more serious footing. See note 4 *supra*. Thus, where a complaint alleges only a modest, individual grievance, it may properly be dismissed for failure to state a civil rights claim. Third, it removes the federal courts from the day-to-day, instance-by-instance administrative determinations that are at the heart of operating a state hospital. The result should be to focus attention where it belongs: on serious abuses that are intolerable in a humane society.

These issues are clearly important. Moreover, like many issues in the field of mental illness and retardation, they have a sense of immediacy that argues in favor of prompt review. State employees within the Third Circuit must now work under the standards imposed by the court of appeals and are subject to damages for failure to make the complicated judgments required of them by the decision below. The result, we believe, may be to impair effective treatment as overly-cautious state employees opt for the safest, though not necessarily the most beneficial, approaches to treatment. In addition, the Third Circuit has continued to follow the policy of linkage begun with *Halderman* v. *Pennhurst State School & Hospital*, 612

F. 2d 84 (1979) (en banc), reversed and remanded —— U.S.L.W. —— (April 20, 1981), applying the principles of this case to the treatment of the mentally-ill in *Scott* v. *Plante*, Nos. 80-1314, 80-1315, and 80-1596 (February 5, 1981), cert. petition pending, No. 80-1699. We, therefore, urge this Court to consider these sensitive issues now.

II. THIS CASE RAISES IMPORTANT QUESTIONS REGARDING THE IMPOSITION OF LIABILITY WITHOUT FAULT FOR CONSTITUTIONAL TORTS.

The decision below also raises a substantial risk that state employees will be held liable for constitutional violations over which they have little or no control. It is an unfortunate fact that many state employees work at institutions that are understaffed or lack adequate facilities. As a result, they may provide care and treatment that falls below acceptable standards, subjecting them to personal liability in damages. This exposure is fundamentally unfair.

In many instances, it is no more just to hold a particular doctor or attendant liable in damages than it is to shoot a messenger bearing bad news. Too often, the employees of a state institution are victims of the same shortcomings as are the patients. They cannot provide a proper level of care, not because they are malicious or insensitive, but because they do not have enough time or the right facilities. Judged under the usual standard for qualified immunity, they may in fact realize that they are providing substandard care but, as individuals, be helpless to do otherwise. The choices thus are severe: to do the best they can; to release the patients (if state law allows), leaving them without care at all; or to resign their positions, making inadequate staffing worse. Unfortunately, perhaps the best choice—to do all that can be done with the resources at hand—

is the choice that confronts them with personal liability for defects beyond their control.

The inequity in this situation arises from several sources. In one sense, of course, it stems simply from efforts to find a defendant to hold liable for violations of constitutional standards. Sovereign immunity shields the states from liability in damages for past wrongs, although they may be compelled to corrective action in the future. *Edelman* v. *Jordan*, 415 U.S. 651 (1974). Thus, the courts must make do with whomever they can get before them, typically the individuals responsible for carrying out state efforts.

The problem is compounded by the awkward distinction between affirmative conduct and inaction. When government officials have taken affirmative action to deny someone his constitutional rights, by initiating an unlawful search or seizure or by ordering or participating in a physical attack, it is a relatively straightforward matter to identify the persons at fault. See, e.g., *Bivens* v. *Six Unknown Named Agents of the Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Scheuer* v. *Rhodes*, 416 U.S. 232 (1974). Implicit in this theory, however, is the idea of choice: that the defendant had an opportunity to respect constitutional rights and did not. Inaction often does not involve the same choice. Where steps must be taken to implement constitutional rights, there must be some recognition of the fact that a particular defendant cannot always take those steps himself.

The issue is one not of the wrong itself, but of responsibility for it. Unlike malpractice standards, which vary according to circumstances, it is not desirable to vary substantive constitutional standards to suit the conditions faced by a particular defendant.[9] But it is

[9] For example, a doctor performing a roadside operation cannot be expected to perform exactly as he would in a hospital operating room. Thus, the standard of care required is varied to suit the

important to assure that the failure to meet the proper standards does not impose liability on persons who have no choice in the matter. Judicially-created doctrines of liability and qualified immunity, as they apply in cases like the present one, appear to do just that.

Although the Third Circuit recognizes a defense of good-faith immunity in these cases, the definition of that immunity appears to give insufficient protection. Under that definition, a state official or employee is entitled to immunity only "if the official or employee was not aware, or had no reason to be aware, of such [constitutional] rights." Pet. App. 43a. See also *Scheuer* v. *Rhodes*, *supra*; *Wood* v. *Strickland*, 420 U.S. 308 (1975). But it is entirely possible, even likely, that state employees in mental hospitals or similar facilities may be acutely aware of their failure to meet constitutional standards but, at the same time, simply have no capacity to do much better. For example, a state psychiatrist may have so large a caseload that he can give only cursory time to any particular patient, a problem that he cannot solve on his own. It will hardly help matters to hold him liable for damages or force him to resign.

One solution is simply to recognize that the immunity defense encompasses not only ignorance of constitutional standards, but good-faith efforts to meet them. Whatever the law may require of state or federal governments, it makes little sense to insist, at pain of damages, that individuals do more than they possibly can do. At best, such a doctrine exacts relief from the wrong party; at worst, it will drive needed state employees to other jobs,

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particular conditions. Where a state is responsible for inadequate conditions, however, it would be self-defeating to lower the constitutional standard itself because plaintiffs then would be prevented from obtaining the injunctive relief needed to improve the conditions.

further damaging the very institutions that plaintiffs seek to improve.[10]

Another solution is to acknowledge that recovery for constitutional torts must depend upon a showing of fault. To impose liability on a particular defendant, it is not enough simply that the plaintiff have suffered injury: he must seek relief against the proper party. If the injury is caused by a lack of resources or personnel, it is likely to be the governmental entity itself, not the individual who works for it, which is responsible. The fact that the State has absolute liability is not a reason to pretend otherwise.

These concerns about individual liability are not illusory. In a subsequent decision, relying heavily on the decision in this case, the Third Circuit has indicated that good-faith efforts to protect constitutional rights might provide a defense to claims for *punitive* damages, but quite plainly not compensatory damages. *Scott* v. *Plante*, *supra*, slip op. at 36. We submit, therefore, that review is necessary to consider not only the substantive standards established by the court of appeals, but also the extent of liability imposed on individuals for failure to meet them.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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[10] It is already difficult, for example, to get good psychiatrists to work in state hospitals. See generally, Note, *Psychiatry in the Public Sector*, 80 Hosp. & Comm. Psychiat. 749 *et seq.* (1979).